No. 94-368

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In the Supreme Court of the United States

OCTOBER TERM, 1994

VERNON HOME HEALTH CARE AGENCY, INC.,
PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Whether a Medicare provider that has accepted assignment of a provider agreement with the Secretary of Health and Human Services as part of a purchase of the assets of a former provider may be held responsible for overpayments made to the former provider under that agreement.

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OPINIONS BELOW

The decision of the court of appeals (Pet. App. 3a-9a) is reported at 21 F.3d 693. The decision of the district court (Pet. App. 1-2) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 1, 1994. A petition for a writ of certiorari was filed on August 29, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

Petitioner provides home health care to Medicare patients. Pet. App. 4. In 1985, petitioner purchased the assets of Vernon Home Health, Inc. (Vernon I), for approximately $23,000. The purchase agreement provided that petitioner would not assume the liabilities of Vernon I. At petitioner's election (see *id.* at 8), Vernon I's Medicare provider agreement and unique provider number were automatically transferred to petitioner. *Ibid.*

In 1984, before the sale of assets, the Secretary of Health and Human Services had notified Vernon I of an overpayment of approximately $30,000 for the fiscal year ended June 30, 1994, and requested repayment of that amount. Pet. 13; Pet. App. 4. Some time after the asset sale, the government filed this action to recover the overpayment, naming both Vernon I and petitioner as defendants. Both petitioner and the government filed affidavits in the district court addressing whether the purchaser of a provider's assets is obligated to repay Medicare overpayments received by the seller before the sale. Pet. App. 5-6. After concluding that the case presented no issues of fact for trial, the district court granted summary judgment in favor of the government. *Id.* at 1-2.

The court of appeals affirmed. Pet. App. 3-9. The court rejected petitioner's contention that the affidavits filed in the district court created an issue of fact, concluding instead that they addressed a legal dispute to be resolved by the district court in the first instance and reviewed by the appellate court *de novo*. *Id.* at 6.

On the merits, the court turned aside (Pet. App. 6-8) petitioner's argument that recovery was barred by state law principles permitting the sale of assets without the

assumption of liabilities. The court reasoned (*id.* at 6-7) that federal rules governing the disbursement and recoupment of funds under a federal benefits program would preempt any contrary provision of state law. In this case, the court looked to 42 C.F.R. 489.18(d), which specifies that a Medicare provider agreement that is assigned to the purchaser of a former provider's assets "is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued." The court pointed out (Pet. App. 7-8) that the "statutory and regulatory conditions" governing provider agreements include adjustments for, and recoupment of, overpayments. Thus, the court concluded (*id.* at 8-9) that the federal scheme "unambiguously require[s] the purchaser of a provider agreement to assume liability for Medicare overpayments made to the prior provider," and that that requirement preempts any contrary state law. *Id.* at 7-8.

The court further remarked (Pet. App. 8) that the Secretary's interpretation of the statute and regulations was "eminently reasonable." The system of interim payments made on the basis of estimated costs, subject to a year-end accounting and the recoupment of any overpayments, "ensures Medicare providers a steady flow of income sufficient to provide service"; and subjecting the assignee of a provider agreement to the same system generally serves to facilitate continuous service to Medicare beneficiaries. *Ibid.* In this case, the court noted, petitioner could have declined automatic assignment of the provider agreement and chosen instead to apply as a new participant, in which case it would have assumed no liability for overpayments under the old agreement. Petitioner chose, however, to accept the benefits of the assignment. The court concluded that petitioner had thereby submitted to the terms and

conditions of the regulatory scheme, including recoupment. *Id.* at 8-9.

ARGUMENT

1. Petitioner contends (*e.g.*, Pet 13, 15-16, 20) that the government's position in this recoupment action—that petitioner is liable for overpayments made to a previous provider under a provider agreement that petitioner voluntarily assumed—rests on a new "interpretive rule" adopted by the Secretary without fair notice to petitioner. That contention mischaracterizes the government's action and ignores the reasoning of the court of appeals.

As the court of appeals explained (Pet. App. 7-8), 42 C.F.R. 489.18(d) explicitly provides that an assigned provider agreement "is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued." Those terms and conditions include provider liability for overpayments of the sort at issue here, which arise from the fact that Medicare is required by statute to make periodic payments on an estimated basis during each fiscal year, subject to a year-end accounting on the basis of actual experience and either a final payment or recoupment of any overpayment by Medicare. See Pet. App. 8; 42 U.S.C. 1395g(a), 1395x(v)(1)(a)(ii); *Good Samaritan Hosp.* v. *Shalala*, 113 S. Ct. 2151 (1993). The decision in this case to seek recoupment from petitioner as the assignee of the provider agreement under which the overpayment in question was made involved no new "interpretive rulemaking" (Pet. 15), but merely application to particular facts of an explicit regulatory requirement.

Petitioner's arguments about the new "interpretive rule" purportedly applied here—that it has been

improperly given retroactive effect (Pet. 17-20); that it violates due process, the Administrative Procedure Act, 5 U.S.C. 551 *et seq.*, and principles of equity because it was not published before implementation (Pet. 20-24); and that it should be more carefully scrutinized when, as here, it preempts state law (Pet. 26-29)—are therefore simply inapposite. This case involves no rule or regulation other than Section 489.18(d), which has been in force since 1980 (see Pet. 18 n.4); and the decision in this particular case rested not on deference to the Secretary's interpretation of that rule, but on the court of appeals' own "*de novo*" review. See Pet. App. 6. Cf. *John Hancock Mut. Life Ins. Co.* v. *Harris Trust & Sav. Bank*, 114 S. Ct. 517, 531 (1993) (noting issue of deference to agency interpretations expressed in litigation).[1]

2. Petitioner challenges (Pet. 17 n.3; see also Pet. 20-24) the court of appeals' holding that Section 489.18(d), and the other statutory and regulatory provisions that it incorporates by reference, impose liability for previous overpayments on successor providers like petitioner. As the court explained (Pet. App. 7-9), however, that result follows logically not only from the language of the

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[1] For the same reason, there is no substance to petitioner's assertion (Pet. 19-20) that the decision below conflicts with the decision in *Health Ins. Ass'n of America* v. *Shalala*, 23 F.3d 412, 422-425 (D.C. Cir. 1994). In *HIAA*, the court indicated that in determining what degree of deference to accord to an agency interpretation embodied in a formal interpretive rule, the court would distinguish between transactions undertaken before and after adoption of the rule. See 23 F.3d at 422, 425. In this case, the court of appeals relied on 42 C.F.R. 489.18(d) and other applicable statutory and regulatory provisions, rather than on any new interpretive rule. There is no dispute that Section 489.18(d) applies to petitioner's acquisition of Vernon I and its succession to Vernon I's provider agreement.

relevant provisions, but from the structure of the Medicare program.

As noted above and by the court of appeals (Pet. App. 8), Medicare relies on a system of interim estimated payments made subject to a final, year-end accounting. That system insures liquidity for providers, as well as uninterrupted service for beneficiaries. Thus, when a new owner acquires the assets of an existing provider and chooses to accept assignment of that provider's reimbursement agreement with Medicare, it should not come as a surprise that the new provider succeeds not only to the seller's rights under that agreement, but also to its obligations—including repayment obligations that may arise out of the routine year-end process of reconciling estimated payments with the provider's actual experience. Petitioner cites no decision that has come to a contrary conclusion, and the matter does not warrant further review.[2]

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[2] If, in fact, petitioner did not recognize its potential successor liability for the overpayments at issue here—about which, as petitioner itself notes (Pet. 13), the Secretary had already notified Vernon I well before the acquisition—then it may have accepted that liability "unknowingly." Pet. App. 9. But even if petitioner failed to appreciate the full legal consequences of its assumption of the provider agreement, or to protect itself contractually against unanticipated liabilities, the result in this case is neither unforeseeable nor unfair. Moreover, as the court of appeals pointed out (*id.* at 8), petitioner could have declined automatic assignment of Vernon I's provider agreement and entered into a new and separate agreement directly with the Secretary, thereby avoiding any possible responsibility for prior overpayments.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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